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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Clinic Name |  | | Address |  | | Phone number |  | | | | | **Work Rehabilitation**  **Initial Evaluation** | | | | | | |
| Worker Name: | | | | Date of Report: | | | | Claim Number(s): | | |
| Accepted Conditions: | | | | | | | Date of Injury: | | Date of surgery:  NA | |
| Attending/Referring Provider: | | | | | | Next AP appointment Date:        Unknown | | | | |
| Job Goal: | | | | | | Physical Demand Level of Job Goal: | | | | |
| Vocational Provider: | | | | | | Job Analysis/Description provided?  Yes  No | | | | |
| Review by client?  Yes  No | | | | |
| Current Work Status: Full-Duty Modified/Light-Duty Not Working Other: | | | | | | | | | | |
| Worker’s Goals for this program: | | | | | | | | | | |
|  | | | | | | | | | | |
| **Current Capacity** | | | | | | | | | | |
| **Demonstrated current positional tolerances**:    Hours per day    Total hours per week | | | | | | | | | | |
| **Sit** for | at a time;    Hours per day | | | | **For combined activities of sit/stand/walk or stand/walk, 2 hours in an 8-hour day is considered within normal limits**. | | | | | |
| **Stand** for | at a time;    Hours per day | | | | Alternately **stand/walk**       at a time;    Hours per day | | | | | |
| **Walk** for | at a time;    Hours per day | | | | Alternately **sit/stand/walk**       at a time;    Hours per day | | | | | |
| Observations: | | | | | | | | | | |
|  | | | | | | | | | | |
| **GROSS MOBILITY/ POSITIONAL ASSESSMENTS:** *(R= Right; L= Left; B= Both)* **Hand Dominance: R L** | | | | | | | | | | |
| Task | | Current weight/  frequency  S, O, F, C, NT | Clinical Observations: *describe body mechanics, barrier to movement patterns or other restrictions* | | | | | | | Job Goal weight/frequency  S, O, F, C, NT |
| Climb: Ladder/Stairs | | / |  | | | | | | | / |
| Twist Neck | | / |  | | | | | | | / |
| Twist Trunk | | / |  | | | | | | | / |
| Bend/Stoop | | / |  | | | | | | | / |
| Kneel | | / |  | | | | | | | / |
| Squat | | / |  | | | | | | | / |
| Reach: Forward | | / |  | | | | | | | / |
| Reach waist to shoulder | | / |  | | | | | | | / |
| Work above shoulders | | / |  | | | | | | | / |
| Grasp (Forceful) | | / |  | | | | | | | / |
| Handle/Grasp | | / |  | | | | | | | / |
| Fine manipulation | | / |  | | | | | | | / |
| Lift | | | | | | | | | | |
| Floor to Waist | | / |  | | | | | | | / |
| Waist to Shoulders | | / |  | | | | | | | / |
| Shoulder to Overhead | | / |  | | | | | | | / |
| Carry | | / |  | | | | | | | / |
| Push/Pull | | / |  | | | | | | | / |

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| **Job Specific Testing:** *Example: Keyboarding, ladder carry, rope pull* | | | | | | | | | | | | | |
| Task 1: | | |  | | | | | | | | | | |
| Task 2: | | |  | | | | | | | | | | |
| **Comments:** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Aerobic Capacity** (*treadmill, step test, TUG)* | | | | **Score/METS** | | | | | **Findings consistent with Physical Demand level:** *Sedentary, Light, Medium, Heavy* | | | | |
|  | | | |  | | | | |  | | | | |
| Comments: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Self-reported functional outcome measures** | | | | | | | | | | | | | |
| Examples: *Oswestry Neck Disability Index; Quick DASH; LEFS; Functional Reach Test* | | | | | **Score** | | | **Result Interpretation** | | | | |
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| **Barriers and Strategies for Recovery** | | | | | | | | | | | | | |
| Describe any barriers identified that may impede recovery? | | | | | | | | | | | | | |
| Identify strategies and suggestions to address barriers: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Treatment Plan & Signature** | | | | | | | | | | | | | |
| What WR program is recommended:  Work Rehabilitation – Conditioning  Work Rehabilitation - Hardening  Anticipated WR Treatment Start Date: | | | | | | | | | | | | | |
| Not a candidate for WR Program. Comments: | | | | | | | | | | | | | |
| Initial Frequency and Duration | | days/week for    weeks | | | | | | | | Starting at   hours/day | | | |
| **Goals:** Progressive over program and reflect changes in functional abilities and duration based on job goal.  *Examples: Occasional lifting floor to waist will increase from 20# to 40# in 2 weeks. Static standing will increase from 10 min to 30 min in 2 weeks.* | | | | | | | | | | | | | |
| 1. | | | | | | | | | | | | | |
| 2.. | | | | | | | | | | | | | |
| 3. | | | | | | | | | | | | | |
| 4. | | | | | | | | | | | | | |
| Plan of Care reviewed with Client  Yes  No | | | | | | | | | | | | | |
| Clinic Name: | | | | | | Clinic Fax Number: | | | | | Clinic Phone Number: | | |
| Therapist(s) Name, Credential | Therapist(s) NPI | | | | | | Therapist(s) Signature | | | | | Date Signed | |
|  |  | | | | | |  | | | | |  | |
| Therapist(s) Name, Credential | Therapist(s) NPI | | | | | | Therapist(s) Signature | | | | | Date Signed | |
|  |  | | | | | |  | | | | |  | |